

Adult Member Health Record

ABOUT YOU

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
DATE OF BIRTH:	AGE:
SOCIAL SECURITY NUMBER:	GENDER:
MARITAL STATUS:	NUMBER OF CHILDREN:
EMPLOYER ADDRESS:	
WORK PHONE:	POSITION TITLE:
PAYMENT METHOD: <input type="checkbox"/> CASH <input type="checkbox"/> CHECK <input type="checkbox"/> CREDIT CARD	

ABOUT YOUR SPOUSE

SPOUSE NAME:
SPOUSE EMPLOYER:
POSITION TITLE:

HEALTH HABITS

DO YOU SMOKE? <input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU DRINK ALCOHOL? <input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU DRINK COFFEE, TEA OR SODA? <input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU EXERCISE REGULARLY? <input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU WEAR:
<input type="checkbox"/> HEEL LIFTS <input type="checkbox"/> SOLE LIFTS <input type="checkbox"/> INNER SOLES <input type="checkbox"/> ARCH SUPPORTS

MEDICATIONS YOU TAKE

<input type="checkbox"/> CHOLESTEROL MEDICATIONS	<input type="checkbox"/> INSULIN
<input type="checkbox"/> STIMULANTS	<input type="checkbox"/> PAIN KILLERS
<input type="checkbox"/> TRANQUILIZERS	<input type="checkbox"/> BLOOD PRESSURE MEDICINE
<input type="checkbox"/> MUSCLE RELAXERS	<input type="checkbox"/> OTHER

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?
HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (✓ALL THAT APPLY): <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> SIGN <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> COMMUNITY EVENT <input type="checkbox"/> MAILING
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, WHAT WAS THE REASON FOR THOSE VISITS?
DOCTOR'S NAME:
APPROXIMATE DATE OF LAST VISIT:
HAS ANY MEMBER OF YOUR FAMILY EVER SEEN A CHIROPRACTOR?

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:
PLEASE BRIEFLY DESCRIBE, INCLUDING THE IMPACT IT HAS HAD ON YOUR LIFE. IF YOU'RE ONLY HERE FOR CHIROPRACTIC WELLNESS SERVICES PLEASE SKIP TO NEXT PAGE: <input type="checkbox"/> WELLNESS <input type="checkbox"/> SPORTS <input type="checkbox"/> AUTO <input type="checkbox"/> FALL <input type="checkbox"/> HOME INJURY <input type="checkbox"/> JOB <input type="checkbox"/> CHRONIC DISCOMFORT <input type="checkbox"/> OTHER
PLEASE EXPLAIN:
WHEN DID THIS CONCERN BEGIN?
HAS THIS CONCERN: <input type="checkbox"/> GOTTEN WORSE <input type="checkbox"/> STAYED CONSTANT <input type="checkbox"/> COME AND GONE
DOES THIS CONCERN INTERFERE WITH: <input type="checkbox"/> WORK <input type="checkbox"/> SLEEP <input type="checkbox"/> DAILY ROUTINE <input type="checkbox"/> OTHER ACTIVITIES
PLEASE EXPLAIN:
HAS THIS CONCERN OCCURRED BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO
PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS FOR THIS CONCERN? <input type="checkbox"/> YES <input type="checkbox"/> NO
DOCTOR'S NAME:
TYPE OF TREATMENT:
RESULTS: <input type="checkbox"/> GOOD <input type="checkbox"/> BAD <input type="checkbox"/> INDIFFERENT

SUPPLEMENTS YOU TAKE

<input type="checkbox"/> ESSENTIAL FATTY ACIDS	<input type="checkbox"/> PROBIOTIC
<input type="checkbox"/> MULTIVITAMIN WHICH:	<input type="checkbox"/> OTHER _____
<input type="checkbox"/> CALCIUM / MAGNESIUM	<input type="checkbox"/> OTHER _____
<input type="checkbox"/> VITAMIN C	<input type="checkbox"/> OTHER _____

Many problems and health challenges can start as 'nerve interference' blocking the vital power that operates and heals our body. Please **CIRCLE** below any concerns you are experiencing now as well as in the past. Feel free to list any other concerns or health challenges you may be having under 'other'.

ARE YOU AWARE THAT...

DOCTORS OF CHIROPRACTIC WORK WITH THE NERVOUS SYSTEM?

YES NO

THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS?

YES NO

CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD?

YES NO

GOALS FOR YOUR CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your Doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Relief care:** Symptomatic relief of pain or discomfort.
- Corrective care:** Correcting and relieving the cause of the problem as well as the symptom.
- Comprehensive care:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.
- I want the Doctor to select the type of care for my condition.**

YOUR CONCERNS

Sore Throat
Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma
High Blood Pressure
Heart Conditions
Thyroid Conditions



C1 Headaches
C2 Migraines
Dizziness
Sinus Problems
Allergies
Fatigue
Head Colds
Vision Problems
T2 Difficulty Concentrating
T3 Hearing Problems
T4 Trouble Sleeping

T5 Middle Back Pain
T6 Congestion
T7 Difficulty Breathing
T8 Bronchitis
T9 Pneumonia
Gallbladder Conditions
Stomach Problems
Ulcers
Gastritis
Kidney Problems

Constipation
Colitis
Diarrhea
Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problems
Low Back Pain
Pain or Numbness in legs
Reproductive Problems
Sexual Dysfunction

OTHER:

HEALTH CONDITIONS...

INSTRUCTIONS: Please check each of the diseases or conditions that you now have or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

<input type="checkbox"/> SEVERE OR FREQUENT HEADACHES	<input type="checkbox"/> THYROID PROBLEMS	<input type="checkbox"/> PAIN IN ARMS/LEGS/HANDS	<input type="checkbox"/> NUMBNESS	FOR WOMEN ONLY:	
<input type="checkbox"/> HEART SURGERY/PACEMAKER	<input type="checkbox"/> SINUS PROBLEMS	<input type="checkbox"/> LOW BLOOD PRESSURE	<input type="checkbox"/> ALLERGIES	ARE YOU PREGNANT?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> LOWER BACK PROBLEMS	<input type="checkbox"/> HEPATITIS	<input type="checkbox"/> RHEUMATIC FEVER	<input type="checkbox"/> DIABETES	IF YES, WHEN IS YOUR DUE DATE?	
<input type="checkbox"/> DIGESTIVE PROBLEMS	<input type="checkbox"/> DIFFICULTY BREATHING	<input type="checkbox"/> ULCERS/COLITIS	<input type="checkbox"/> SURGERIES:	ARE YOU NURSING?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> PAIN BETWEEN SHOULDERS	<input type="checkbox"/> KIDNEY PROBLEMS	<input type="checkbox"/> TUBERCULOSIS	<input type="checkbox"/> ASTHMA	ARE YOU TAKING BIRTH CONTROL? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> CONGENITAL HEART DEFECT	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> LOSS OF SLEEP	DO YOU:	
<input type="checkbox"/> FREQUENT NECK PAIN	<input type="checkbox"/> CHEMOTHERAPY	<input type="checkbox"/> SHINGLES	<input type="checkbox"/> DIZZINESS	EXPERIENCE PAINFUL PERIODS?	<input type="checkbox"/> YES <input type="checkbox"/> NO
				HAVE IRREGULAR CYCLES?	<input type="checkbox"/> YES <input type="checkbox"/> NO
				HAVE BREAST IMPLANTS?	<input type="checkbox"/> YES <input type="checkbox"/> NO

SURGERIES: (PLEASE LIST ALL SURGERIES YOU HAVE HAD)

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there may be a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.

Prior to receiving chiropractic care in this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed before treatment. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan to help you become healthier prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments and other modalities, as reported following my assessment.

_____ Patient Name (printed) _____ Relationship to patient

_____ Patient or legal Guardian Signature _____ Date

_____ Witness Signature (office staff) _____ Date

CANCELLATION AND NO-SHOW POLICY

We do our best to schedule as efficiently as possible to minimize wait times while maintaining our standard of care. If you cannot make your scheduled appointment time, we request the courtesy of **2 hours** notice. Available appointments are in high demand and your early cancellation will give another patient the opportunity to make use of your allotted time. We understand that special unavoidable circumstances may arise, however less than 2 hours notification may be subject to a **\$25.00 fee**.

Patients who fail to show up to their designated appointment altogether will be considered a NO SHOW. Each no show will be charged a \$25 inconvenience fee. For practice members who have pre-purchased a pack of visits, one no show will count as one visit. Three late cancellations will also count as one visit. Cancellation fees are not covered by your insurance and will be charged the day of.

PATIENT SIGNATURE _____ (Date) _____
(Or Patient Representative) (Indicate relationship if signing for patient)

OFFICE SIGNATURE _____ (Date) _____

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine and other joints, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

SIGN IF READ ABOVE _____ DATE _____

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

At Essential Chiropractic Studio, we use an 'open adjusting' area. If at any time you prefer or need a 'closed' adjusting area, or would like to discuss your health in the privacy of a closed room, please communicate this to a member of our staff.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT):

RELATIONSHIP TO PATIENT:

SIGNATURE:

DATE: